

RIVER CITY CHIROPRACTIC PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name _____ Today's Date ____/____/____
Date of Birth ____/____/____ Age: ____ Birth Height: ____ Birth Weight: ____ Current Height: ____ Current Weight: ____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Mother's Mobile: _____ Father's Mobile: _____
Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____
Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____

CHILD'S CURRENT PROBLEM

- Purpose of this visit: Wellness Check-up Injury or Accident Other Please Explain: _____
- What is your child's chief complaint(s)? (If applicable) _____
- When did the problem first begin? Date ____/____/____ Gradual Sudden Unknown
 - Ever had this problem before? No Yes If yes when? _____
 - Have you seen any other doctors for this problem? No Yes If yes who? _____ When? ____/____/____
 - What were the results of past treatment? _____
 - On a scale of 0 to 10 with 10 being the worst pain and 0 being no pain, rate your child's above complaint(s) by circling the number:
Primary: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Secondary: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
 - Please list any medication your child is currently taking: _____
 - Has your child sustained any past injuries? (Explain) _____
 - Any past surgeries? (Explain) _____
 - Has your child ever been in an auto accident? No Yes if yes; please explain _____
 - Any other problems the doctor should know about? (Explain) _____

PLEASE MARK "P" FOR PAST, "C" FOR CURRENT, AND "N" FOR NEVER FOR EACH OF THE FOLLOWING FOR YOUR CHILD

- | | | | | |
|-------------------------|---------------------|-------------------------|-------------------------|--------------------------|
| ___ Headaches | ___ Muscle Pain | ___ Hypertension | ___ Poor Appetite | ___ Growing Pains |
| ___ Neck Pain/Problems | ___ Joint Problems | ___ Heart Trouble | ___ Bed Wetting | ___ Fainting |
| ___ Back Pain/Problems | ___ Poor Posture | ___ Digestive Disorders | ___ Colic | ___ Dizziness |
| ___ Orthopedic Problems | ___ Scoliosis | ___ Stomach Aches | ___ Diarrhea | ___ Seizures/Convulsions |
| ___ Walking Trouble | ___ Broken Bones | ___ Constipation | ___ Anemia | ___ Ruptures/Hernia |
| ___ Leg Problems | ___ Sinus Trouble | ___ Reflux | ___ Behavioral Problems | ___ Sleeping Problems |
| ___ Arm Problems | ___ Chronic Earache | ___ Asthma | ___ ADD/ADHD | ___ Colds/Flu |
- ___ Major Falls (Explain) _____ Allergies: _____

INFORMED CONSENT

By my signature below I am acknowledging treatment objectives as well as the risks associated with chiropractic adjustments, therapies, x-rays and all other procedures provided at River City Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of all to the doctor on behalf of my child. After careful consideration, I do hereby consent to a full examination, diagnostic x-rays (if necessary), and treatment by any means, methods, and or techniques the doctor deems for the benefit of my minor child, for whom I have the legal right to select and authorize health care services on behalf of. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

I hereby authorize payment to be made directly to River City Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources on behalf of my child. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to River City Chiropractic for any and all services my child receives at this office.

Parent or Legal Guardian's Signature

Date

Witness Initial

AFFECTS OF DAILY LIVING

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely a part of their life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by statements below, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

PERMITTED DISCLOSURES:

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas mean open discussion, if you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes: To obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: To process a claim or aid in investigation.
5. Emergency: In the event of a medical emergency we may notify a family member.
6. For public health and safety: In order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement: To identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons: For discussion with coroners and medical examiners in the event of a patient’s death.
10. Telephone calls or emails and appointment reminders: We may call your home and leave messages regarding a missed appointment or update you of changes in practice hours or upcoming events.
11. Change of ownership: In the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive detailed privacy notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to copy your xrays onto a CD for personal records there is a \$10 administration fee to do so.

I understand my rights as well as the practice’s duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this “Notice of Privacy Practice” at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name

DOB

Patient Signature

Date

Witness

Date